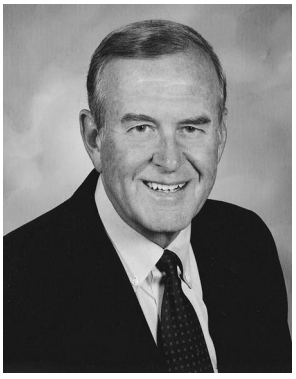
Cesarean Delivery on Request

Where Do We Go From Here?



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Editor

Almost a 30% cesarean delivery rate in 2004 and still rising—unbelievable! Moreover, the movement to perform a cesarean delivery in the absence of a medical indication has been building for over a decade. Brazil was one of the first countries where cesarean delivery on request became popular,[1] ethicists have proposed that cesarean delivery is a woman's right,[2] and cesarean delivery has most recently been publicized as a way to avoid incontinence and prolapse problems.[3–4] Consequently, more physicians and patients today believe that cesarean delivery is a fast, safe, and convenient way to have a baby.

The problem is that most of this is opinion-based rather than evidence-based. This wave of enthusiasm is suspiciously similar to early campaigns for continuous electronic fetal monitoring, tocolysis to prevent preterm birth, and mandatory trial of labor. There are no randomized controlled trials and few prospective long-term studies to show that the benefits of requested elective cesarean delivery outweigh the risks compared with vaginal delivery. Since it is doubtful that randomized trials can now be accomplished, how should this issue be resolved?

The National Institute of Child Health and Human Development and the Office of Medical Applications organized and just completed a State-of-the-Science Conference on Cesarean Delivery on Maternal Request. Scientific evidence was presented to address four major questions: 1. What is the trend and incidence of cesarean delivery over time in the United States and other countries? 2. What are the short-term (under 1 year) and long-term benefits and harms to mother and infant associated with cesarean delivery by request versus attempted vaginal delivery? 3. What factors influence benefits and harms? 4. What future research directions need to be considered to get evidence for making appropriate decisions regarding cesarean delivery on request or attempted vaginal delivery?

An impartial, independent panel was charged with reviewing the available published literature in advance of the conference, including a systematic review of the literature commissioned through the Agency for Healthcare Research and Quality. The first day and a half of the conference consisted of presentations by expert researchers and practitioners and open public discussions. The panel then presented a statement of its collective assessment of the evidence to answer each of the questions and held a press conference to address the media. We have published the conference statement on pages 1386–97.

This is one of the most important and controversial issues facing our specialty, and a conference to focus on this problem was appropriate and needed. More than 500 people attended, and the question and answer sessions were lively and often heated. Many of the comments from the audience were personal, biased, and anecdotal, but it is apparent that

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there are numerous advocacy groups that are concerned about and opposed to the direction in which we are going. The presentations pretty much confirmed what we know–there are few reliable data on which to base decisions.

In my view, the conference will be a success if it stimulates high-quality studies that yield more reliable data. Only then can clinicians and patients make good decisions regarding cesarean delivery on request versus vaginal delivery. What is my advice after attending the conference and listening to the available evidence? Go slow on this for now, be cautious, don't get caught up in the rhetoric, and individualize until better evidence is available and the ultimate consequences are well known. To do otherwise just might come back to haunt us.

REFERENCES

1. Finger C. Caesarean section rates skyrocket in Brazil. Many women are opting for caesareans in the belief that it is a practical solution. Lancet 2003;362:628.
2. Minkoff H, Powderly KP, Chervenak F, McCollough LB. Ethical dimensions of elective primary cesarean delivery. Obstet Gynecol 2004;103:387–92.
3. Rortveit G, Daltveit AK, Hannestad YS, Hunskaar S. Urinary incontinence after vaginal delivery or cesarean section. N Engl J Med 2003;348:900–7.
4. Eason E, Labrecque M, Marcoux S, Mondor M. Anal incontinence after childbirth. CMAJ 2002;166:326–30.